

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

## CERTIFICATE OF DEATH

Rng. Dist. No. 01590 1850

1. PLACE OF DEATH: *Charles Wadley md*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*Mo* County.....*Chas*  
 City or town.....*Wadley*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Emma Blanche Allen*

## 3. (b) Social Security Number

4. Sex.....*F* 5. Color or race.....*Coe* 6.(a) Single, married, widowed, or divorced.....*married*  
 6.(b) Name of husband or wife.....*Charles*  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....*Apr 5 - 1874*

8. AGE: Years.....*74* Months.....*10* Days.....*5* If less than one day..... hrs..... min.....

9. Birthplace.....*Louisville St Mary Co*  
 (Town, county, and state)

10. Usual occupation.....*House wife*

11. Industry or business.....

12. Name.....*William Stone*

13. Birthplace.....*Louisville St Mary Co md*

14. Maiden name.....*Madison*

15. Birthplace.....

16. Informant.....*Charles Allen*

Address.....*Wadley md*

17. *Burial* Date thereof.....*2-13-46*  
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory.....*St Marys*

Location.....*Wadley md*

18. Funeral director.....*Smith & Ryder*

Address.....*Wadley md*

19. *2-12* 19. *47* *M. L. Morris*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*2 1 10* 19.....*47* at.....*6 P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*1945* 19..... to.....*2 1 10* 19.....*47*

and that I last saw him.....*20* alive on.....*2 1 10* 19.....*47*

Immediate cause of death.....*Cerebral Apoplexy*

Due to.....*Cardio-Vas-*

Due to.....*Renal Dis*

Other conditions.....*Hypertension*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*C. J. Wabner M.D.* M. D. or other

Address.....*Wadley, Md.* Date signed.....*2/1/47*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

## CERTIFICATE OF DEATH

01591

Reg. Dist. No. 100

## 1. PLACE OF DEATH

County..... *Charles*  
 City or town..... *Bryantown*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... *14 days*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md.* County..... *Charles*  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*M. Henrietta Boorman*

## 3. (b) Social Security Number

4. Sex

*F*

5. Color or race

*W*

6. (a) Single, married, widowed, or divorced

*Single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

*July 21, 1871*

6. (c) If alive, give age..... years

8. AGE:

*75**6**12*

It less than one day

hrs.

min.

9. Birthplace

*Bryantown, Chas. Co., Md.*  
(Town, county, and state)

10. Usual occupation

*Nursing*

11. Industry or business

MOTHER FATHER

12. Name

*Dr. William I. Boorman*

13. Birthplace

*Bryantown, Md.*

14. Maiden name

*Estelle Gardiner*

15. Birthplace

*Chaptico, Md.*

16. Informant

*Mrs. Gladys E. Williams*

Address

*Bryantown, Md.*

17.

(Burial, cremation, or removal, Which?)

Date thereof

*2/6/47*  
(month) (day) (year)

Cemetery or crematory

*St. Mary's*

Location

*Bryantown, Md.*

18. Funeral director

*Herbert H. Mason*

Address

*Wheaton, Md.*

19.

(Date rec'd by registrar)

19.

*John H. Peay*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*2-3*19.. *47*.. at *4 A*.. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*1-27*19.. *47*.. to *2-3*19.. *47*..

and that I last saw h. e. alive on

*2-2*19.. *47*..

Immediate cause of death

DURATION

*Cancer of Rectum**1-27-47*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*John H. Peay**M. D.*

M. D. or other

Address

*Wheaton, Md.*Date signed *2-3-47*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 01592

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....  
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace.....

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal. Which?)

Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. 2-17-47  
(Date rec'd by registrar)

19.....

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

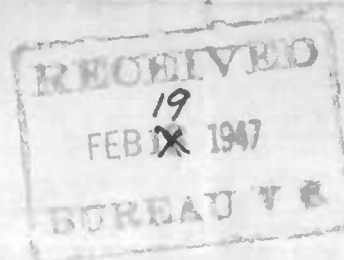
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



1-30-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1020

01593

## 1. PLACE OF DEATH

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Old Single

## 6.(b) Name of husband or wife

6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days It less than one day  
 18 hrs. min.

9. Birthplace.....  
 (Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name.....  
 13. Birthplace.....  
 14. Maiden name.....  
 15. Birthplace.....

16. Informant.....  
 Address.....

17. (Burial, cremation, or removal, which?) Date thereof.....  
 (month) (day) (year)

Cemetery or crematory.....  
 Location.....

18. Funeral director.....  
 Address.....

19. 49 Feb 11 47 J. V. Thompson  
 (Date rec'd by Registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19..... at 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
 and that I last saw him..... alive on.....

Immediate cause of death.....

Brochial Pneumonia.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

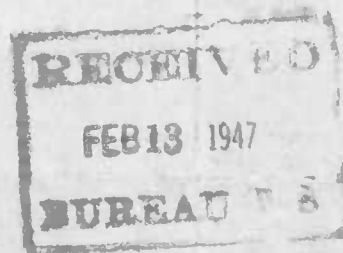
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

George C. Bicknell, M.D.  
 Address..... Date signed.....





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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

01594

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County Charles  
 City or town La Plata  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution: Thyminis Memorial  
10da.  
 Stay in hospital or inst. (yrs., or mos., or days)  
 Stay in this community (yrs., or mos., or days)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD. County Charles  
 City or town \_\_\_\_\_ Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. \_\_\_\_\_  
 (If rural give LOCATION)  
 2(a) IF VETERAN, NAME WAR \_\_\_\_\_

## 3. (a) FULL NAME

Alice Permelia Cooksey

## 3. (b) Social Security Number

4. Sex 7 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married  
 6 (b) Name of husband or wife Fairfax Cooksey  
 6 (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Dec. 6, 1872  
 8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chaptico, St. Marys, Md.  
 (Town, county, and state)  
 10. Usual occupation Housework

11. Industry or business Columbus Bilkerton  
 12. Name St. Mary's Co. Md.  
 13. Birthplace Nannie Davis  
 14. Maiden name St. Mary's Co. Md.  
 15. Birthplace

16. Informant William F. Cooksey  
 Address Spring Hill, Md.

17. Burial Date thereof 2/5/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Sacred Heart  
La Plata, Md.  
 Location

18. Funeral director Hunt & Ryan  
Waldorf, Md.  
 Address

19. 2-5- 19 47 Julia H. Posey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 19 47 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7 19 46 to February 2 19 47  
 and that I last saw her alive on February 2 19 47

Immediate cause of death Cerebral Thrombosis -  
General visceral Failure.

## DURATION

2 weeks

Due to Hypertensive - Atherosclerotic  
Cerebrovascular Disease

10 yrs. +

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Please underline  
 the cause to which  
 death should be  
 charged statisti-  
 cally.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Larran J. Jurek, M.D.  
La Plata, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 2/2/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## CERTIFICATE OF DEATH

COMMONWEALTH OF MARYLAND  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

01595

1. PLACE OF DEATH

County of CharlesRegistration District No. 320

Township of \_\_\_\_\_

File No. \_\_\_\_\_

or  
Borough of \_\_\_\_\_  
or \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. 1050City of Bryantown (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a Hospital or Institution give its NAME instead of street and number.)

2. FULL NAME Mary Lucille Farmer

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE COLORED 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6. DATE OF BIRTH (month, day, and year) MAY 13 19467. AGE Years \_\_\_\_\_ Months 9 Days \_\_\_\_\_ IF LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ or \_\_\_\_\_ min.

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employerBaby9. BIRTHPLACE (city or town) Bryantown  
(State or country) Charles, Maryland10. NAME OF FATHER Raymond Allen Farmer11. BIRTHPLACE OF FATHER (city or town) Centerville  
(State or country) Charles, Maryland12. NAME OF MOTHER Mary Dorothy Sewell13. BIRTHPLACE OF MOTHER (city or town) Hughesville  
(State or country) Charles, Maryland14. Informant Raymond Allen Farmer  
(Address) Father Bryantown, Md.15. Filed 2-13, 1947 M. L. Mowbray  
11-3184 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 13 1947  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from, Feb 12 1947, to FEB 12 1947, that I last saw her alive on FEB 12 1947 and that death occurred, on the date stated above, at 3:30 A.M.  
The CAUSE OF DEATH\* was as follows:  
Pneumonia, bronchoCONTRIBUTORY (SECONDARY) Hepatitis, infections  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8-10 ds.  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3-4 ds.18. Where was disease contracted  
If not at place of death? \_\_\_\_\_Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Alfred R. Lapin M. D.  
Feb 12 1947 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL St MarysDATE OF BURIAL 2-13 194720. UNDERTAKER Elmer Guade  
ADDRESS Hughesville

MARGIN RESERVED FOR BINDING

INLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact description of OCCUPATION is very important. See instructions on back of certificate.

PARENTS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

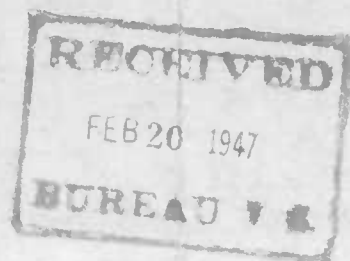
## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B72)

## CERTIFICATE OF DEATH

01596  
Reg. Dist. No. 1020

<b>1. PLACE OF DEATH</b> County..... <i>Charles</i> City or town..... <i>Baltimore</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <i>Maryland</i> County..... <i>Charles</i> City or town..... <i>Baltimore</i> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name was	
<b>3. (a) FULL NAME</b> <i>Judy Lee Keys.</i>		<b>3. (b) Social Security Number</b>	
<b>4. Sex</b> <i>F</i>	<b>5. Color or race</b> <i>White</i>	<b>6. (a) Single, married, widowed, or divorced</b> <i>Single.</i>	
<b>6. (b) Name of husband or wife</b>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <i>Feb. 9 1947</i>			
<b>8. AGE:</b> Years Months Days If less than one day <i>— — 9 —</i> hrs. min.			
<b>9. Birthplace</b> <i>Baltimore, Charles Co. Md.</i> (Town, county, and state)			
<b>10. Usual occupation</b>			
<b>11. Industry or business</b>			
<b>FATHER</b>	<b>12. Name</b> <i>William Francis Thomas.</i>		
	<b>13. Birthplace</b> <i>Charles Co. Md.</i>		
<b>MOTHER</b>	<b>14. Maiden name</b> <i>Catherine Fono Key</i>		
	<b>15. Birthplace</b> <i>Charles Co. Md.</i>		
<b>16. Informant</b> <i>Louisa Montgomery</i> Address <i>Grayton Md.</i>			
<b>17. Burial</b> Date thereof <i>Feb. 18 1947</i> (Burial, cremation or removal. Which?) (month) (day) (year) Cemetery or crematory <i>Cal. Grove</i> Location <i>Pinkie, Md.</i>			
<b>18. Funeral director</b> <i>William T. Montgomery</i> Address <i>Grayton Md.</i>			
<b>19. Feb 18 1947</b> (Date rec'd by registrar) Registrar <i>J. V. Thompson</i>			
<b>MEDICAL CERTIFICATION</b>			
<b>20. DATE OF DEATH</b> <i>Feb 18 1947</i> at <i>5:55</i>			
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> .....19..... to.....19..... and that I last saw him..... alive on.....19..... Immediate cause of death..... <i>Congenital Cardiac Disease.</i> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.			
<b>22. VIOLENCE: If death was due to external causes, fill in the following;</b> Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?			
<b>23. SIGNATURE</b> <i>Geo. C. Bicknell M.D.</i> Address..... <i>Maryland</i> Date signed <i>Feb 18 1947</i>			



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01597

1060

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, year).....

8. AGE: Years..... Months..... Days.....  
It less than one day..... hrs. .... min.9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal. Which?).....  
Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

20. (Date signed by registrar).....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him/her on.....

Immediate cause of death.....

Chronic Myocarditis.....

DURATION.....

2 years.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....



RECEIVED

FEB 28 1947

BUREAU 7 8

2-35



2411 N. Charles St., Baltimore Md.

# CERTIFICATE OF DEATH

Reg. Diat. No. 1000

## 1. PLACE OF DEATH:

County Charles  
City or town La Plata  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? En route  
Hospital, institution, or street address where death occurred:  
En route Physicians Memorial Hospital  
How long in hospital or institution? Did not arrive

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Charles  
City or town Papies Creek  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. "Hushbury"  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

John Blackburn Mullikin

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mich 24 - 1896 1891

8. AGE: Years Months Days If less than one day  
50 50 50 50 hrs. min.

9. Birthplace Georgetown K.G.  
(Town, county, and state)  
Town Foreman

10. Usual occupation

## 11. Industry or business

12. Name Mullikin

13. Birthplace "

14. Maiden name Mullikin

15. Birthplace

16. Informant Edna Mullikin

Address Papies Creek Md

17. Burial Date thereof 2-26-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Georgetown Cemetery

Location Georgetown K.G.

18. Funeral director Waldorf

Address Waldorf Md

19. 2-23 1947 M. C. Mullikin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 19 47 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on

February 21, 1947 to Feb 21, 1947  
and that I last saw him live on Feb 21, 1947

Immediate cause of death

Probably  
coronary thrombosis

## DURATION

Minutes

Due to

Coronary

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

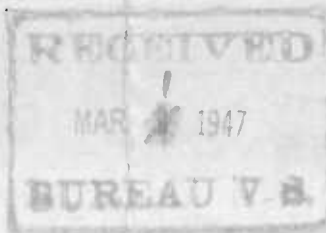
Injured at work?

23. SIGNATURE James E. MacKavanaugh, M.D.  
Address La Plata, Md Date signed 2-26-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469

## CERTIFICATE OF DEATH

015990  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... *Charles*City or town..... *Welcome*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md.* County..... *Charles*City or town..... *Welcome, Md.*  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Joseph Adrian Owen*

## 3. (b) Social Security Number

## 4. Sex

*M*

## 5. Color or race

*W*

## 6. (a) Single, married, widowed, or divorced

*Married*

## 6. (b) Name of husband or wife

*Myrtle Owens*

## 6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

*Feb. 19, 1896*

## 8. AGE:

Years

Months

Days

If less than one day

*50*

hrs.

min.

## 9. Birthplace

*Welcome, Md.*  
(Town, county, and state)

## 10. Usual occupation

*Merchant*

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

*John W. Owens*

## 13. Birthplace

*Chas. Co. Md.*

## 14. Maiden name

*Mamie Welch*

## 15. Birthplace

*Chas. Co. Md.*

## 16. Informant

*Mrs. Myrtle Owens*

## Address

*Welcome, Md.*

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

*2-4-47*  
(month) (day) (year)

## Cemetery or crematory

*Arlington National*

## Location

*Arlington Va.*

## 18. Funeral director

*Hunt & Ryan*

## Address

*Waco, Md.*

## 19.

(Date rec'd by registrar)

19

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Feb. 2, 1947* at *2:45 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*November 1946* to *Feb. 2, 1947*and that I last saw him alive on *Feb. 1, 1947*

Immediate cause of death

*Carcinoma of the head  
of the parotid*

## DURATION

*6 mos*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations *Carcinoma of parotid*Date of op. *1-8-47*

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

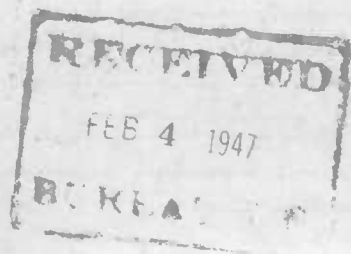
Means of injury

Injured at work?

23. SIGNATURE..... *John L. Mackay, M.D.*

M. D. or other

Address..... *Waco, Md.* Date signed *2-2-47*



1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

950

01600

## CERTIFICATE OF DEATH

Reg. Dist. No. 10.11

1. PLACE OF DEATH: *Charles Hill Top*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *70 yrs*  
 Hospital, institution, or street address where death occurred:

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Maryland* County *Charles*  
 City or town *Hill Top*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

How long in hospital or institution?

2.(a) If veteran, name war.....

3. (a) FULL NAME *Alexander Ward*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *old* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Helen Ward*

7. Birth date of deceased (mo., day, yr.) *1873* 6. (c) If alive, give age..... years

8. AGE: Years *75* Months *12* Days *13* If less than one day..... hrs. .... min.

9. Birthplace *Hill Top, Charles Co., Md*  
 (Town, county, and state)

10. Usual occupation *Farming*

11. Industry or business

12. Name *Wallace Ward*

13. Birthplace *Charles Co., Md*

14. Maiden name *Unknown*

15. Birthplace *"*

16. Informant *Randolph Ward*  
 Address *Hill Top, Md.*

17. *Burial* Date thereof *2. 20. 47*  
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetary or crematory *Fion*

Location *Hill Top, Md*

18. Funeral director *Stanley Perry*  
 Address *Perryville Md*

19. *Feb. 19* 19 *47* *Mrs. B. B. Borne*  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 17* 19 *47* at *9 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Oct. 46* to *Feb. 47*

and that I last saw him alive on *Jan. 47*

Immediate cause of death *Chr. Cardiac Disease*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

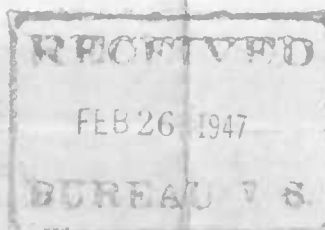
Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE *L. C. Bicknell*  
 M. D. or other *Marbury Md*  
 Address..... Date signed *Feb. 17, 47*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-1010

— 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01601

Reg. Dist. No. 100 0

## 1. PLACE OF DEATH:

County..... Charles

City or town..... La Plata, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Charles

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lina Watts

## 3. (b) Social Security Number

Watts

## 4. Sex

Female

## 5. Color or race

Negro

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Matt Watts

## 6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

Unknown 1879

## 8. AGE:

68 3

## Months

## Days

## If less than one day

..... hrs. .... min.

## 9. Birthplace

Chas. Co. Md.  
(Town, county, and state)

## 10. Usual occupation

housework

## 11. Industry or business

## MOTHER FATHER

## 12. Name

Unknown

## 13. Birthplace

Susan Lancaster

## 14. Maiden name

Chas. Co. Md.

## 15. Birthplace

Sherman Watts

## 16. Informant

## Address

La Plata, Md.

## 17.

(Burial, cremation, or removal, Which?)

## Date thereof

2/11/47  
(month) (day) (year)

## Cemetery or crematory

Mt. Rest

## Location

La Plata, Md.

## 18. Funeral director

Huntt &amp; Ryan

## Address

Wadsworth, Md.

## 19.

2-11  
(Date rec'd by registrar)

## 19.

47

Julia H. Perry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 8, 1947, at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 1944 to Feb. 8, 1947

and that I last saw him alive on Feb. 5, 1947

## Immediate cause of death

General thrombosis

## DURATION

2 wks

## Due to

Generalized arteriosclerosis

3-4 yrs.

## Due to

Other conditions: Chronic myocarditis with

coronary atherosclerosis  
(Include pregnancy within 3 months of death)

1 yr.

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

## Means of injury

## Injured at work?

## 23. SIGNATURE

James L. Mackenzie, M.D.

M. D. or other

## Address

La Plata, Md.

Date signed: 2-8-47



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FEB 13 1947

BUREAU

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 01602 788

### 1. PLACE OF DEATH:

County Charles  
City or town Panthers  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Charles

City or town Panthers  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

James O. Hinkler

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White b.(a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 18, 1879 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 67 Months 9 Days 26 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Charles County, Maryland  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Anthony Hinkler

13. Birthplace Charles County, Maryland

14. Maiden name Bridget Adams

15. Birthplace Charles County, Maryland

16. Informant Mrs. Hattie Hinkler

Address Panthers, Maryland

17. Burial Date thereof 2-17-47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Joseph's

Location Panthers, Maryland

18. Funeral director Walter E. Lynn

Address Wachow, Maryland

19. 2/16 19 47 Julia H. Posey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 19 47, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-6 19 39 to Dec 19 47  
and that I last saw him in alive on 2-14 19 47

Immediate cause of death Arterio Sclerotic  
gangrene

Due to Gen. Art. Sclerosis

Due to Hemiplegia

Other conditions \_\_\_\_\_  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. H. Hinkler M.D.  
Lablata, Md. M. D. or other \_\_\_\_\_  
Date signed 2-15-47

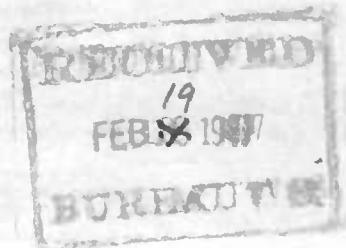
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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RECEIVED



1-35